AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act of 1996
45 C.F.R. § 164.508

Name of person/organization disclosing health information:

_____
_____

Name of individual/client whose specific health information is being disclosed:

_____

Describe the protected health information to be disclosed in sufficient detail to enable both the individual signing this authorization and DES to clearly identify the health information authorized for disclosure:

_____
_____
_____

Name of person/organization receiving the health information:

_____
_____
_____

Describe the specific purpose of this release. The statement "*at the request of the individual*" is sufficient when an individual initiates the authorization.

_____
_____

This authorization's expiration date, event, or condition:

_____

If no expiration date or condition is specified, this authorization shall expire one year from the date of this authorization.

I understand that I may revoke this authorization at any time by written notice to the person/organization named above that is disclosing my health information, except to the extent that the disclosure authorized has been acted upon prior to the receipt of any written revocation.

I understand that I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization except as provided under state or federal law.

I understand that once the records and information authorized herein are disclosed, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, health care service providers generally are bound by contract and law to maintain the confidentiality of the health information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, substance abuse, psychological or psychiatric conditions or genetic testing.

I understand that I may have a copy of this signed authorization if I request it.

_____ Date signed_____
(Print full name of individual/client
or personal representative)

_____
(Signature of individual /client or personal representative)

Description of personal representative's authority: _____
_____
(If applicable)

*Note: This authorization was revoked/withdrawn in writing on (date) _____
Signature of staff: _____

A Facsimile or Photocopy of this Authorization is Considered To be as Authentic as the Original

[This form is not endorsed or approved by any official organization or entity. It is offered as one basic example of a HIPAA compliant form. It does not authorize the use or disclosure of substance abuse information or HIV/AIDS related information. The user of this form assumes all responsibility and liability for its use.]